THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-05-2977.M5

MDR Tracking Number: M5-04-3810-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on July 6, 2004.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the neurological re-education, myofascial release, therapeutic procedures-group, therapeutic exercises and aquatic therapy **were not found** to be medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 07-30-04 the Medical Review Division submitted a Notice to the requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The carrier denied CPT codes 97112, 97113, 97250 and 97110 for date of service 07-08-03 as "E – Entitlement to benefits". However, the carrier did not raise any issues pertaining to liability for the claim in accordance with 124.2; therefore, the carrier's denial of "E" is invalid.

In accordance with Rule 129.5, the requestor submitted relevant information to support delivery of service for CPT codes 97112, 97113, and 97250 for date of service 07-08-03 therefore, recommends reimbursement of $35.00(neuromuscular reeducation) + $52.00(aquatic therapy) + $43.00(myofascial release) = $130.00 in accordance with the Medical Fee Guideline.

CPT code 97110- Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation.

The MRD declines to order payment for code 97110 because the daily notes did not indicate whether the doctor was conducting exclusively one-to-one sessions with the claimant, the notes did not clearly indicate activities that would require a one-on-one therapy session, the notes did not indicate the type of activity/therapy, the notes did not reflect the need for one-on-one supervision and there was no statement of the claimants medical condition or symptoms that would mandate one-on-one supervision for an entire session or over an entire course of treatment.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this Order. This Order is applicable to date of service 07-08-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 22nd day of September 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

PR/pr

September 17, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-3810-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
------ Case #:

------ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ------ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ------ for independent review in accordance with this Rule.

------ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ------ external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ------ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ------ for independent review. In addition, the ------ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a female who sustained a work related injury on ------. The patient reported that while at work she injured her back. The patient underwent a lumbar MRI on 10/25/01 that was reported to have shown dessication of the disc at L4-5 with moderate posterior disc bulging. The diagnoses for this patient have included lumbar herniated nucleus pulposus. Treatment for this patient's condition has included myofascial released, neurological reeducation, therapeutic procedures, therapeutic exercises and aquatic therapy.

Requested Services

Neurological reeducation, myofascial release, therapeutic procedures-group, therapeutic exercises and aquatic therapy from 7/7/03 through 7/11/03.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Retrospective Peer Review 6/26/03
2. Progress Summary 4/26/03 – 7/10/03
3. Functional Capacity Assessment 6/19/03

Documents Submitted by Respondent:

1. Same as above

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is upheld.

Rationale/Basis for Decision

The ------ chiropractor reviewer noted that this case concerns a 42 year-old female who sustained a work related injury to her back on ------. The ------ chiropractor reviewer indicated that an MRI of the lumbar spine performed on 10/25/01 revealed dessication at the L4-5 disc with moderate posterior bulging and that electrodiagnostic studies revealed no evidence of right lumbar radiculopathy or neuropathy. The ------ chiropractor reviewer noted that treatment had included various manual and physical therapy modalities, along with therapeutic activities, therapeutic procedures, therapeutic exercises and aquatic therapy. The ------ chiropractor

reviewer also noted that a lumbar evaluation performed on 4/17/03 revealed decreased lumbar and lower extremity ranges of motion, a postural disturbance, hyposensitivity and myofascial restriction. The ------ chiropractor reviewer indicated that weekly progress summaries revealed decreased ranges of motion with slow progress towards goals reaching nearly 100% of the goals by the twenty first session. The ------ chiropractor reviewer explained that in order for extended treatment to be medically necessary, there must be documented progress submitted by the provider. The ------ chiropractor reviewer indicated that the patient sustained her injury in 9/01 however the treatment in question began 19 months after the date of injury. The ------ chiropractor reviewer explained that at this time the patient's condition was no longer acute but that the patient is placed in a treatment plan with great frequency and intensity. The ------ chiropractor reviewer also explained that the patient had normal electrodiagnostic studies and an MRI revealing no evidence of spinal stenosis or foraminal compression and that throughout care the patient had essentially the same complaints treated with the same care. The ------ chiropractor reviewer further explained for treatment to be medically necessary there must be an expectation of recovery or improvement within a generally accepted time frame. The ------ chiropractor reviewer indicated that additional care would be medically necessary if objective benefit can be demonstrated. The ------ chiropractor reviewer explained that there was no evidence of lasting benefit and that there were no examination findings or test results that indicated continued care.

Therefore, the ------ chiropractor consultant concluded that the neurological reeducation, myofascial release, therapeutic procedures-group, therapeutic exercises and aquatic therapy from 7/7/03 through 7/11/03 were not medically necessary to treat this patient's condition.

Sincerely,